Progress of the Head and Neck Pathway Group

Mr Peter Clarke, Chair of the LCA Head and Neck Pathway Group
Progress update: The Head and Neck Pathway Group

- Implementation with NHSE Transforming Cancer Services Team (TCST) and London Cancer of a new pan London 2ww form for suspected head and neck cancers – up-date

- Review of specialised head and neck cancer surgery across the LCA

- Neck Lump rapid diagnostic clinic progress up-date

- Enhanced Recovery self-assessment and benchmarking questionnaire coming to you soon

- Commissioning intentions 2016/17 – proposed changes or additions to next years commissioning intentions (see next slides)
Commissioning Intentions 2016/17

- **All** GPs to have direct access to non-obstetric ultrasound for low risk, not no risk cancers
- **70% of patients** will receive a Holistic Needs Assessment
  - Identify needs and concerns early
  - Prevent concerns or problems escalating
  - Aid self-supported management
- **70% of patients** will attend a health and well being event
  - Support self-management any anticipated health needs
  - Health promotion to make long term lifestyle changes
  - NCSI defined as one-stop information clinic for active recovery
- **70% of patients** will receive a treatment summary
  - Information for GPs to manage their patients proactively
  - Information for GPs to complete a cancer care review
  - Information for patients to take an active role in their own health
- Service providers of cancer services will be **required** to follow **NICE guidance on smoking cessation**
Objectives for today

1. Recommendations from CNS mapping

2. Understanding of timing and requirements for Treatment Summaries. How the Pathway Group can help with this.

3. Take away guidance for improving access to radiotherapy post Head and Neck Surgery.

4. Understanding of specialist support for patients with osteoradionecrosis.
Head and neck nursing model for LCA/Thyroid

Alison Leary
Chair, Healthcare & workforce modelling
@alisonleary1
Project remit

- Demand and supply model (emancipatory)
- One cancer group across one large locality (LCA) for one tumour type
- No stochastic calcs or modelling
- Takes approx five days of analyst time and 1-2 days of nurse time
- Generates a lot of data!!!
Methods

- Current activity using the a priori reference dataset, activity and level of practice-checking assumptions
- Bespoke data collection tool
- Demand modelling (pre existing population data, horizon scanning, unpaid OTE, care left undone, SWOT, Gap, local activity, NCPES)
- Effect on supply (education, time, complexity of practice, functional MDT, availability of other services-plasticity has to be considered)
Checking assumptions

• Level of complexity PCM, RCM or facilitative? How many PCM junctions?
• Caseload does not equal workload
• Factor against data set and other SCI models
• Delivery against cancer standards
General findings for the group

- 17 responses 15 used 9 orgs
- Only one site not represented.
- 100% use title CNS
- Only 1 vacant WTE but long term sick leave
- Most people had access to full MDT
- Hours provided

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Paid</th>
<th>Unpaid OTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery hours</td>
<td>234</td>
<td>210</td>
<td>24</td>
</tr>
<tr>
<td>Oncology hours</td>
<td>368</td>
<td>305</td>
<td>63</td>
</tr>
</tbody>
</table>
N = 15

Number of years in H&N

- 1-3 years: 1
- 4-6 years: 3
- 7-10 years: 4
- Over 10 years: 7
Caseload (static) n=16

Case load totals across LCA

- 101-200: 4
- 201-300: 2
- 301-400: 2
- Greater than 600: 1
- Less than 100: 6
Admin burden n=16

- Chasing routine results
- Typing letters
- Routine appointments
- Routine investigations
- Routine transport
- Database entry
- Other clerical
Work left undone & MDT

- Primarily psycho-social
- HNA
- Symptom control
- Most likely to be left undone at progressive disease
- Most worked in functional MDT
- 4 regularly not told about new patients
- 5 felt uncomfortable challenging other members and 2 found the meeting intimidating.
## Access to CPD

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am currently participating in education/CPD</td>
<td>37.50%</td>
<td>6</td>
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<td>- My last educational opportunity/CPD has been within the last year</td>
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<td>8</td>
</tr>
<tr>
<td>- My last educational opportunity/CPD was longer than one year ago but within the last two years</td>
<td>0.00%</td>
<td>0</td>
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<tr>
<td>- My last educational opportunity/CPD was over two years ago</td>
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<td>- I find it hard to find funding for education/CPD</td>
<td>18.75%</td>
<td>3</td>
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<tr>
<td>- I find it hard to obtain study leave for education/CPD because of workload</td>
<td>18.75%</td>
<td>3</td>
</tr>
<tr>
<td>- I find it hard to obtain study leave for education/CPD because of other factors</td>
<td>12.50%</td>
<td>2</td>
</tr>
<tr>
<td>- I do not currently require education/CPD</td>
<td>6.25%</td>
<td>1</td>
</tr>
<tr>
<td>- Would rather not say</td>
<td>0.00%</td>
<td>0</td>
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</tbody>
</table>
CPD n=16

- Other
- Would rather not say
- Not required
- Research courses/modules
- Leadership programmes
- Clinical skills study days
- Specialist update study days
- Prescribing qualification (V300)
- Advance practice courses i.e. full physical assessment & history taking
- Masters level modules
- Degree level modules
Other referral centres
Southampton/Portsmouth
Bournemouth/Poole
East Sussex
(Brighton/Hastings)
Gibraltar for thyroid

SGH
Largest for H&N + Thyroid

GP- smoking/alcohol
Cessation
Ongoing prescriptions

RMH Sutton
Pain, Palliative, Psych, OT, Physio, SALT, Dental, Dietician

RMH Chelsea
Thyroid largest
Some H&N

Thyroid Ca
Follow up-
Life long

Community Palliative Care Teams
(All H&N + Thy)

Paeds Unit
Thy

Psychological Support Services eg Paul’s Centre Clapham

Left undone meeting information needs, psycho/social HNA in Tx, FU, PD, EOLC
1.5 WTE both PH OTE >10 hours PW
No admin support apart from some letters very high admin burden
Offset burden 20 hours admin support
0.6 PCM CNS 1 WTE Rookie
SWOT RMH Sutton

Strengths & opportunities

• Strengths:
  • Organisation study days
  • Experience
  • Visible knowledge
  • Approachability
  • High level of service
  • Equitable care
  • Shared care among CNS
  • Teamwork

• Opportunities:
  • Immediate post-treatment follow up
  • More psychological input
  • Smoking cessation programme on site
  • Paid overtime/extra contracted hours
  • Sharing expertise across LCA
  • Self-education

Weakness & threats

• Weaknesses:
  • Long term FU
  • HNA’s
  • Not enough paid hours
  • Performing admin tasks
  • Pt can’t get through on telephone
  • Time for research
  • Reactive service at times
  • No weekend cover
  • Output prioritised over input
  • Time for self-education

• Threats:
  • HNA’s CQuin
  • Unmanageable workload (thyroid pts)
  • Staff burn out
  • Reputation of trust
  • Mismanagement of resources
Gap analysis RMH Sutton

- Admin staff- typists clinic letters/booking clinic/transport
- Band 5/6 to support thyroid patients
- Clinic rooms for F.U.
- Managers to push through FU clinics
- Protected time within working hours for smoking cessation programme
- Protected time and nurse cover to complete masters programme
Findings

- **MVH** A nursing deficit is apparent at Mount Vernon. The caseload is tertiary (refer in and out) however there is an accruing caseload as more patients are followed up on site. There are a high number of medical staff generating activity and nursing does not appear to have been matched as the service has developed (H&N and ENT). There are several solutions to the deficit such as 1 WTE CNS/ANP or a developmental post supported by the two experienced current post holders.

- **RMH** Chelsea No substantial deficit
- **RMH** Sutton Very high admin burden, high level of work left undone and thyroid practice is large—as a tertiary centre this is unlikely to change. Admin support would offset burden (20 hours plus pw) plus consider at least 20 hours pw for Thyroid (experienced post) or a developmental post (1 WTE) for service.

- **GSTT** High admin support at least 20 hours. No deficit with current establishment but currently 1 LT sick and 1 WTE vacancy. Consider developmental post if unable to recruit
Findings (cont)

- **NWL** Allowing for current vacancies no substantial deficit if posts filled. Experienced post holder planning to retire and succession planning needs some thought.
- **Imperial** No substantial deficit however largely facilitative work with opportunities ie nurse led services. Suggest admin support and investment in new posts (1 CNS/WTE) if services develop.
- **Kings** Little data offered. Caseload stated as less than 100 assume 1 WTE is sufficient
- **SGH** Data offered through on line collection. Appears to be single handed practice, surgical focus and high admin burden-post holder works 4-7 hours pw unpaid OT. Some psychosocial work left undone. Caseload 101-200, likely to require some admin support.
- **Ealing** Little data offered. Caseload stated as less than 100 but cannot assume 0.5 WTE is sufficient
- **WMID** No data provided
Conclusion

• “rough and ready” workforce modelling found defect in some areas (nursing and admin time)
• Can be used for stochastic calcs
• Could be used for ROI calcs
• Feedback for the participants has been excellent
Treatment summaries for Head and Neck – the GSTT experience

Dr Mary Lei, Consultant Clinical Oncologist, GSTT
Plan

• Rationale
• GSTT experience
• Suggestions
What is a Treatment Summary?

• A summary of all the information related to that person’s cancer and its treatments

• Provides an overview of:
  – Treatment to date, including treatment intent
  – Side effects experienced during treatment and any anticipated long(er) term consequences
  – Signs of recurrence/red flags
  – Follow-up plan
  – On-going prescriptions
  – Referrals to other services
  – In- and O-OH contact details
What’s the rationale?

• Increasing cancer incidence and prevalence
• Increasing requirements on GPs to support those LWBC
• Increasing CNS workload
• People living with and beyond cancer need to be able to self-manage on-going cancer related consequences
• National piloting showed
  – People didn’t have the right information to know what to worry about and who to contact with those worries
  – GPs didn’t know either! And didn’t have the right information to complete a Cancer Care Review
  – Treatment summaries filled this gap and were feasible and practicable according to acute hospital Drs
  – 50% of GPs reported a change in their practice as a result
<table>
<thead>
<tr>
<th>METRICS</th>
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<tbody>
<tr>
<td><strong>1</strong> % of patients that receive HNA at diagnosis</td>
</tr>
<tr>
<td>Evidence:</td>
</tr>
<tr>
<td>- Evidence within the patient records of HNA having completed</td>
</tr>
<tr>
<td>- Evidence of actions completed in response to the HNA i.e. a care plan</td>
</tr>
<tr>
<td>Performance Measurement:</td>
</tr>
<tr>
<td>- Q1 50%</td>
</tr>
<tr>
<td>- Q2 55%</td>
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<tr>
<td>- Q3 60%</td>
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<tr>
<td>- Q4 60%</td>
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<tr>
<td>- In cases where the target is not met, an action plan for improvement will be required and an expected improvement of 10% required in the following quarter</td>
</tr>
<tr>
<td><strong>2</strong> % of patients who are offered an end of treatment consultation</td>
</tr>
<tr>
<td>Evidence/quality measures:</td>
</tr>
<tr>
<td>- Evidence of the treatment summary having been completed</td>
</tr>
<tr>
<td>- Evidence of end of treatment HNA and care plan being completed</td>
</tr>
<tr>
<td>Assurance/Performance Measurement:</td>
</tr>
<tr>
<td>- Q1 40%</td>
</tr>
<tr>
<td>- Q2 50%</td>
</tr>
<tr>
<td>- Q3 60%</td>
</tr>
<tr>
<td>- Q4 60%</td>
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<td><strong>3</strong> % of new patients who have access to a health and wellbeing event at the end of primary treatment</td>
</tr>
<tr>
<td>Evidence:</td>
</tr>
<tr>
<td>- Evidence in patient record of event being offered</td>
</tr>
<tr>
<td>Performance Measurement:</td>
</tr>
<tr>
<td>- Q1 LCA Lead baseline audit of available events</td>
</tr>
<tr>
<td>- Q2 30%</td>
</tr>
<tr>
<td>- Q3 40%</td>
</tr>
<tr>
<td>- Q4 50%</td>
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<tr>
<td>Diagnosis:</td>
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<th>Treatment Aim:</th>
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<td></td>
<td>Yes / No</td>
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<tr>
<td></td>
<td>DS 1500 application completed</td>
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<td>Prescription Charge exemption arranged</td>
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<td>In Hours:</td>
</tr>
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<th>Other service referrals made: (delete as nec)</th>
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<tr>
<td>District Nurse</td>
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| Required GP actions in addition to GP Cancer Care Review (e.g. ongoing medication, osteoporosis and cardiac screening) | |
|---------------------------------------------------------------------------------------------------------------|

| Summary of information given to the patient about their cancer and future progress: | |
|-----------------------------------------------------------------------------------------------|

| Additional information including issues relating to lifestyle and support needs: | |
|------------------------------------------------------------------------------------------|
How and when is it completed?

- The Dr who holds the end of treatment consultation is responsible for it’s completion
- Already on Somerset and Infoflex, so some fields can pre-populate
- Generic content, by diagnosis
- Dictation crib sheets?
- Role of medical secretaries?
- Should be completed within six weeks of end of treatment
Further reading


The GSTT experience

- Implemented Nov 2013 for all H&N oncology pts
- Timing: EOT review with oncologist
- Method: dictated into EOT letter template
<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Date of Diagnosis:</th>
<th>Organ/Staging</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Local/Distant</td>
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<th>DS 1500 application completed</th>
<th>Prescription Charge exemption arranged</th>
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<tr>
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</tr>
</tbody>
</table>

**Required GP actions in addition to GP Cancer Care Review** (e.g. ongoing medication, osteoporosis and cardiac screening)

**Summary of information given to the patient about their cancer and future progress:**

**Additional information including issues relating to lifestyle and support needs:**
TREATMENT SUMMARY

Your patient has now completed their initial treatment for cancer. A summary of their diagnosis, treatment and on-going management plan are outlined below. The patient will also receive a copy of this summary.

<table>
<thead>
<tr>
<th>Surgical Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology Consultant</td>
</tr>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>Date of diagnosis</td>
</tr>
<tr>
<td>Treatment aim</td>
</tr>
</tbody>
</table>

Summary of completed treatment and relevant dates

<table>
<thead>
<tr>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiotherapy</td>
</tr>
<tr>
<td>Chemotherapy</td>
</tr>
<tr>
<td>Clinical studies</td>
</tr>
</tbody>
</table>

Possible treatment related toxicities and/or late treatment side-effects and other relevant clinical information

<table>
<thead>
<tr>
<th>Medication on completion of treatment</th>
</tr>
</thead>
</table>
### Follow up

The patient will be followed up by the Community Head and Neck team (CHANT). Contact details: LH.CHANT@nhs.net 020 3049 2350

The patient will be followed up by the dietetics service at GSTT. Contact details: 02071884128

Next Oncology appointment will be in 6 weeks *(amend time as appropriate)*
Next Surgical appointment will be in xx weeks *(amend time as appropriate)*
Next Dental appointment will be in xx weeks *(amend time as appropriate)*

The patient will require a PET scan in 3m time *(amend or delete as appropriate)*

An Holistic Needs Assessment with be offered to the patient by CHANT in 6-10 weeks time and care plan to be completed to address any needs or concerns raised

The next Wellness Afternoon where various aspects of ongoing care will be discussed is on xxxxxx

Patient has been referred to palliative care

### Required GP actions in addition to GP Cancer Care Review

1. Continue to prescribe medication *(further information in the management of treatment side-effects can be found in the links below)*.
2. Yearly monitoring of thyroid function tests *(starting 1yr following completion of treatment)* due to the risk of hypothyroidism in patients who have received radical radiotherapy to the neck.
3. Monitoring of blood pressure, cholesterol and glucose levels.
4. Monitoring of renal function

Delete those that do not apply and add any that apply. Some may need additional explanation: e.g.: patient’s most recent U&Es show K of xx and urea of xx due to reduced intake and chemotherapy. Please continue supplementation and monitoring.

### Summary of information given to...

Patient has been advised that...
He/she should not smoke. A referral to GSTT smoking cessation services...
| **Summary of information given to the patient about their cancer and future progress:** | Specify what information given to patient and what advice (free text)
- Was treatment curative or **palliative**. If palliative what information on prognosis
- What is going to happen with side effects and what to do
- What info leaflets (copies of the information leaflets given to patients can be found in the links below)
- **FU info** |
| **Additional information including issues relating to lifestyle and support needs:** | Patient has been advised that
- He/she should not smoke. **A referral to GSTT smoking cessation services has been arranged/declined by patient**
- He/she should not drink alcohol
- He/she should keep alcohol consumption to a minimum
- Information on holistic needs assessment (HNA) given
- Invitation to the next Wellness event **on XXX**
  Any additional support the patient requires |
| **Advise entry onto primary care, palliative or supportive care register** | Yes or no |
| **DS 1500 application completed** | **Not known** |
| **Prescription Charge exemption arranged** | **Not known** |
| Prescription Charge exemption arranged | District Nurse  
<table>
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<tbody>
<tr>
<td>Other service referrals made:</td>
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<tr>
<td>(delete as nec)</td>
<td>Social Worker</td>
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<td></td>
<td>Dietitian</td>
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<td></td>
<td>Lymphoedema Clinic Referral</td>
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<td></td>
<td>Audiology</td>
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<td>Other</td>
</tr>
</tbody>
</table>

**Alert Symptoms that require referral back to specialist team:**

If you or the patient notice any of the following, do not wait until the next appointment. Please refer patient to be seen without delay:

1. Development of a new lump/bump in the neck
2. Noisy breathing
3. Worsening voice quality
4. New mouth ulcer or white patch
5. Increased difficulty swallowing
6. Increased pain

**Information resources**

| Contacts for referrals or queries | In hours:  
|----------------------------------|-------------------|  
|                                  | Eric Martin, PA to Dr T Guerrero Urbano and Dr M Lei.  
|                                  | Phone: 020 7188 4219. Email: eric.martin@gstt.nhs.uk |  
|                                  | **Out of hours:** On call Oncology SpR via switchboard 020 7188 7188 |  
|                                  | **Acute Oncology contact details:**  
|                                  | In hours: Phone: 020 7188 3754 |  
|                                  | Out of hours: Phone: On call Oncology Registrar via switchboard 020 7188 7188 |  
|                                  | **Link to LCA Acute Oncology directory:**  
|                                  | http://www.londoncanceralliance.nhs.uk/media/47978/LCA%20%20AOS%20Directory%20(abridged)%20June%202013.pdf |  
| Radiotherapy to the head and neck | [Link](http://www.guysandstthomass.nhs.uk/resources/patient-information/00delete/Radiotherapytotheheadandneck.pdf) |  


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</tbody>
</table>

Radiotherapy to the head and neck: [Link](http://www.guysandstthomas.nhs.uk/resources/patient-information/00/delete/Radiotherapytotheheadandneck.pdf)

Managing the side effects of head and neck radiotherapy: [Link](http://www.guysandstthomas.nhs.uk/resources/patient-information/cancer/radiotherapy/Managing-side-effects-head-neck-radiotherapy.pdf)

Anti-sickness medicines after your chemotherapy: [Link](http://www.guysandstthomas.nhs.uk/resources/patient-information/cancer/antisickness-medicines-after-chemotherapy.pdf)

Head and Neck chemotherapy regimens information: [Link](http://www.londoncanceralliance.nhs.uk/information-for-healthcare-professionals/forms,-protocols-and-guidance/south-east-london-cancer-network/oncology/head-neck/)

Head and neck chemotherapy consent forms: [Link](http://www.londoncanceralliance.nhs.uk/information-for-healthcare-professionals/forms,-protocols-and-guidance/south-east-london-cancer-network/chemotherapy-consent-forms/head-and-neck-chemotherapy-consent-forms/)
Performance

- Denominator defined by LCA as any pt commencing first treatment (whether surgery, RT or chemo) per month – therefore difficult to assess performance as only oncology currently implementing
- 100% for pts completing radical RT
- ?? For pts completing palliative RT
- Variable for pts completing palliative chemotherapy due to structure of oncology review
- Challenging for doctors to dictate (use laminated copy as prompt)
- Challenging for secretaries to transcribe
Positives

• Well received by rehab team (CHANT)
• Unclear benefit to GPs
• Possibly faster for secretaries to type once accustomed to template
• Standardised information, useful to trainees
Negatives

• Time consuming

• Repetitive – eg toxicities and management in addition to medication box

• Drs and secretaries have to be trained

• Several items with answer unknown at time of dictation eg DS1500

• Unclear how or whether information is actioned by GPs
What can be improved?

- **Possible** treatment related toxicities: standard info re: toxicities and appropriate management built in rather than dictated (or selection of drop down equivalents)

- Possibly additional box to highlight specific G3 toxicities and/or serious complications during treatment eg DVT, hospital admissions
What can be improved?

• Follow up: free text

• Summary of info to pt: currently suggested items are repetitive, can be simplified

• Additional info: numbered options, HNA??

• Advise entry to 1/pall/supp care register: unclear whether noted by GP

• DS 1500/Prescription charge: unknown
What can be improved?

• Other service referrals: free text
• Considering implementation of voice recognition – will change way we dictate and approve letters
What we would like you to do

Please break into 4 groups to review the questions and A3 treatment summaries on the tables and annotate all the boxes that require additional content. Please indicate what content is missing so a bank of information can be generated to be included / copied into each treatment summary.

Thank you
LCA HES Analysis of Head and Neck Operations
Discharges in 2012/13, 2013/14 and 2014/15
Total/Partial Laryngectomy and Total Pharyngectomy

Mr Peter Clarke, Chair of the LCA Head and Neck Pathway Group
LCA HES Analysis of Head and Neck Operations
Discharges in 2012/13, 2013/14 and 2014/15
Total/Partial Laryngectomy and Total Pharyngectomy

Liz Chart
V8/10-11-15
07825314136
Spells with any mention of E291, E292, E293, E294, E296, E298, E299 (laryngectomies) or E191 (total pharyngectomy) in Op1-Op8 fields with Length of Stay >=8 days.

Source: HES
Spells with any mention of E291, E292, E293, E294, E296, E298, E299 (laryngectomies) or E191 (total pharyngectomy) in Op1-Op8 fields with Length of Stay >=8 days.

Source: HES. Includes cancer and non-cancer diagnoses and PP’s.
The London Cancer Alliance

Spells with any mention of E291, E292, E293, E294, E296, E298, E299 (laryngectomies) or E191 (total pharyngectomy) in Op1-Op8 fields with Length of Stay >=8 days.

Source: HES. Includes cancer and non-cancer diagnoses and PP’s. Consultant with 29 ops at Trust B and 17 at Trust C is same individual.
LCA Head and Neck Pathway
Discharges per year: 2012/13, 2013/14, 2014/15
Total/Partial Laryngectomy and Total Pharyngectomy Operations
Length of Stay: Upper quartile, Median, Lower quartile
Next Steps:

• Thoughts?

• Quality prospective audit for 2016/17
## Quality audit for 2016

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Source</th>
<th>Codes / Approach</th>
<th>Issues/ Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Stay-1 calendar year (1/1/16-31/12/16)?</td>
<td>COSD</td>
<td>Current codes from initial audit – collected centrally</td>
<td>Use same inclusion criteria. LoS over 10 days</td>
</tr>
<tr>
<td>Pt experience</td>
<td>Local audit</td>
<td>None – cannot use NCPES as not able to link to specific surgery</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>HES / COSD</td>
<td>Age Consultant (A/B/C)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type of surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Days on ITU</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Day of discharge</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Area</td>
<td>Local audit</td>
<td>Details</td>
</tr>
<tr>
<td>----</td>
<td>-----------------------</td>
<td>---------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4</td>
<td>Complications</td>
<td>Local audit required</td>
<td>Stage of tumour Pathology Previous RT – 5x5 field or larynx plus neck/CRT Pre op HB and weight Length of operation Puree/soft/full diet Hb and Weight on discharge Unexpected return to theatre Day medically fit for discharge Reason for delay where delayed</td>
</tr>
<tr>
<td>5</td>
<td>Fistula rates</td>
<td>Local surgical audit</td>
<td>? How are these captured? MDT data or only surgical notes Yes/no</td>
</tr>
<tr>
<td>6</td>
<td>Oral intake</td>
<td>Local audit</td>
<td>Date/ day post op of commencing oral intake What is considered normal / acceptable? Depends on surgery</td>
</tr>
<tr>
<td>7</td>
<td>Voice outcomes</td>
<td>Primary puncture – Yes/no</td>
<td>What / how is this measured?</td>
</tr>
<tr>
<td>8</td>
<td>SLT outcomes</td>
<td>Secondary puncture date/planned/ not planned</td>
<td>What / how is this measured?</td>
</tr>
</tbody>
</table>
Aims & Objectives

• Inform the LCA of the Jaw Necrosis clinic
• Present the current protocols within the clinic
• Highlight the need for multi-disciplinary care for ORN
• Explore the potential for collaboration and future research
Background

- ORN first reported in 1922 by Regnuad
- Almost a century on...
- Incidence ranges from
- IMRT hypothesised as the saviour
  - ORN: 7%
- HPV more oropharyngeal cancer
- Increase use of CRT

ORN HERE TO STAY...FOR NOW
# Insight into patient SW ORN treatment

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>FFF → RFFF → RFFF → Pec Major → Lat Dorsi</td>
</tr>
<tr>
<td>Theatre time</td>
<td>73 hours</td>
</tr>
<tr>
<td>Other Tx</td>
<td>5 sessions of HBOT</td>
</tr>
<tr>
<td>Ward Stay</td>
<td>161 days</td>
</tr>
<tr>
<td>Investigations</td>
<td>MRI, 3 x Angio, 3 x CTs</td>
</tr>
</tbody>
</table>

**OUTCOME** → *Unresolved ORN*
GSTT Necrosis Clinic
Necrosis Clinic - MDT Guidance Document

Version 1.0: November 2014

Review Date: November 2015

- 34 page document
- Pathways
- Guidance
- Recommendations
- Contacts
- Multi-disciplinary
- Trust approved
- Committee
- Dental Clinical Governance
- AB prescribing
- Available Intra-net
The London Cancer Alliance

**Oncology Services**

**Head and Neck Clinic**
- OMFS
- ENT
- Plastics
- Oncology

**Oncology Clinic**
- Head and Neck
- Breast
- Urology
- **Haematology**

**Dental Assessment Clinic (Pre-XX)**
- Sedation & Special Care
- Oral Surgery

**Jaw Necrosis Clinic**
- Oral Surgery

**Dental Rehab Clinic**
- Restorative
- Oral Surgery
Jaw Necrosis Clinic

- Started in November 2014
- Lead by Oral Surgery
- Multi-disciplinary approach
- Consists of a MDM
- Regular meeting
Core Members in Necrosis team

Chris Sproat (Cons – Oral Surgery)
Vinod Patel (Assoc Spec - Oral Surgery)
Jerry Kwok (Cons – Oral Surgery)
Louise Ormondroyd (StR – Oral Surgery)
Mary Burke (Cons – Sed & Sp Care)
Damien Reilly (Spec Dent – Sed & Sp Care)
Andrew Lyons (Cons – OMFS)
Richard Oakley (Cons – ENT)
Teresa Guerrero Urbano (Cons – Oncology)
Janine Mansi (Cons – Oncology)
Aims & Objectives of the clinic

**Primary**
- To manage all patients presenting with established jaw necrosis in a consistent manner via multidisciplinary approach
- To manage all patients requiring Oral Surgery who are at risk of jaw necrosis (following medication or head and neck RT)

**Secondary**
- Provide a tertiary service
- To contribute to the body of research evidence in jaw necrosis
# Current Clinical Status

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORN patients</td>
<td>77</td>
</tr>
<tr>
<td>MRONJ patients</td>
<td>52</td>
</tr>
<tr>
<td>No. of MDM sessions</td>
<td>4</td>
</tr>
<tr>
<td>MDM patients</td>
<td>23</td>
</tr>
</tbody>
</table>
EPR Referral

- Electronic
  - Logged
  - Instant
  - Under the patient’s name
  - Easy – Like ordering bloods/scans
- Internal
- Reduces referral time
- Avoid clinical risk
  - Delay referrals
  - Lost referrals
Website Referrals

Undergraduate self referrals

Dentist / GP / consultant referrals

Jaw necrosis clinic

The department of oral surgery draws from multiple disciplines for the management of patients with established jaw necrosis as well as those at risk of developing jaw necrosis when dental extractions are required.

The team is made up from a range of different healthcare professionals including dental (oral surgery, sedation and special care, restorative), surgery (oral and maxillofacial, ear nose throat, plastics), oncology (head and neck, breast, prostate, multiple myeloma), and auxiliaries (dietetics, speech and language, physiotherapy).

Those patients that fit these criteria can be referred to the clinic via this referral form (Word 140Kb). Referrers should be aware that this clinic cannot provide routine dental care or treatment and referral requesting will not be accepted.
Pathways
The London Cancer Alliance

**Established ORN**

**Asymptomatic**
- Pentoxifylline 400 mg BD
- Vitamin E 1000IU OD
- Chlorhexidine mouthwash 0.2% 10 ml BD
- Nystatin 100,000U QDS 2/52
- Clinical review 3/12
- Nutritional screening/referral

**Symptomatic**

**Acute**
- Antibiotics
  - 1st line: Co-Amoxiclav 625mg TDS 5/7
  - 2nd line: Metronidazole 400mg TDS 5/7
  - *severe infection or poor response consider dual antibiotics*
  - Chlorhexidine mouthwash 0.2% 10 ml BD
  - Nystatin 100,000U QDS 2/52
  - Clinical review 5/7
  - Nutritional screening

**Chronic**
- Doxycycline 100mg OD 2/12
- Pentoxifylline 400 mg BD
- Vitamin E 1000IU OD
- Chlorhexidine mouthwash 0.2% 10 ml BD
- Clinical review 3/12
- Nutritional screening

**Multiple acute infections or chronic infections with no improvement**

**Treatment**
- CT (CBCT vs Medical CT) – If appropriate
- Surgical intervention – If appropriate
- Consider continuation of medical management to supplement surgery
- Nutritional optimisation/Dietitian referral

- Clodronate should be prescribed by the clinicians discretion
- Stage 4 ORN patients must be presented at MDM initially to determine whether their management be transferred to the Head and Neck Team
Dental Extraction consideration for Head and Neck Radiotherapy Patients

Clinical & Radiographic Examination

ASYMPTOMATIC

RESTORABLE
GDP

UNRESTORABLE
LEAVE

SYMPTOMATIC

RESTORABLE
GDP

UNRESTORABLE & REQUIRES EXTRACTION

- Request Radiation Bath (if possible)
- Start pentoxifylline 400mg BD and Vitamin E 1000 IU OD 1/52 pre-operative

On day of Surgery
- Stat dose Antibiotics
  1st Line: Amoxicillin 500mg
  2nd Line: Metronidazole 400mg
  3rd Line: Clindamycin 600mg

Post-operative
- Continue pentoxifylline 400mg BD and Vitamin E 1000 IU OD until mucosal healing
- Antibiotics 2/52
  1st Line: Amoxicillin 500mg TDS
  2nd Line: Metronidazole 400mg TDS
  3rd Line: Clindamycin 150mg QDS
- Chlorhexidine 0.2% 10 ml BD
- Clinical Review 2/52

Consider impact of extractions on nutritional intake and referral to dietician as appropriate

Primary closure only required where achievable where no additional soft tissue intervention necessary
All extractions should be flapless where achievable
## Review

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Underlying Risk</th>
<th>Review post intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental extraction</strong></td>
<td>Head and Neck RT</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Dental extraction</strong></td>
<td>Oral BPs</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Dental extraction</strong></td>
<td>IV BPs, DB, AAs</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Asymptomatic established necrosis</strong></td>
<td>Head and Neck RT, BPs, AAs</td>
<td>Year 1: 3 monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 2+: 6 monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If patient becomes symptomatic then to re-attend sooner*</td>
</tr>
<tr>
<td><strong>Symptomatic established necrosis</strong></td>
<td>Head and Neck RT, BPs, AAs</td>
<td>2 weeks until asymptomatic</td>
</tr>
<tr>
<td><strong>Referral to Necrosis MDT</strong></td>
<td>Head and Neck RT, BPs, AAs</td>
<td>If management continuing with necrosis clinic then review as next scheduled clinic</td>
</tr>
</tbody>
</table>
MDT Meeting
<table>
<thead>
<tr>
<th>Outcome Code</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Treatment as agreed by MDT and to be managed on Necrosis Clinic</td>
</tr>
<tr>
<td>2</td>
<td>Treatment as agreed by MDT and to be managed by Head &amp; Neck</td>
</tr>
<tr>
<td>3</td>
<td>Treatment as agreed by MDT and to be managed by Oncology</td>
</tr>
<tr>
<td>99</td>
<td>MDT decision deferred until further information available. Requires re-presentation at next MDM</td>
</tr>
</tbody>
</table>
First Name
Surname
Hospital No
• 68Y Male

• Diagnosis: T1N0M0 SCC left floor of mouth + lateral tongue
  – Wide local incision + 1° closure & Sentinel node Bx
  – PORT 60 Gy in 30# (Aug 2013) w/ Levels I & left IIa

• GSTT: T Guerrero Urbano & Prof McGurk

• C/O
  – E/O draining sinus
  – LL exposed bone lingual

• RMH
  – macular degeneration, psorasis, prostate Ca (radical radiotherapy),
    skin ca nose, anxiety, visual impairment

• SH
  – Builder/Carpenter. 2 oz/week 40yrs. 4-6 cans beer per day.

• Nutritional Information
  – Soft food. Odynophagia.
• Imaging
  – Head/neck/chest CT (2013)
  – Mandible CT March 2015

• Provisional Plan
  – P&Ve
  – Doxycycline 100mg
  – M/W H2O2 and CHX
  – ? reconstruction
Outcomes
## ORN data

<table>
<thead>
<tr>
<th>Radiation Delivery</th>
<th>No. of ORN cases</th>
<th>No. receiving additional chemotherapy</th>
<th>Cause</th>
<th>No. of ORN related to initiating factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBT</td>
<td>49</td>
<td>23</td>
<td>Induced</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Spontaneous</td>
<td>26</td>
</tr>
<tr>
<td>IMRT</td>
<td>13</td>
<td>7</td>
<td>Induced</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Spontaneous</td>
<td>11</td>
</tr>
</tbody>
</table>
## ORN data

<table>
<thead>
<tr>
<th>Management Strategy</th>
<th>Notani Grade</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>P&amp;Ve only</strong></td>
<td>18 (11)</td>
<td>4 (1)</td>
<td>3 (2)</td>
<td>25 (14)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>P&amp;Ve, Antibiotics</strong></td>
<td>11 (3)</td>
<td>3 (1)</td>
<td>8 (2)</td>
<td>22 (6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>P&amp;Ve, Surgical debridement</strong></td>
<td>2 (0)</td>
<td>7 (5)</td>
<td>1 (1)</td>
<td>10 (6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>P&amp;Ve, Resection</strong></td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>3 (2)</td>
<td>3 (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>P&amp;Ve, HBOT</strong></td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>2 (0)</td>
<td>2 (0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>31 (14)</strong></td>
<td><strong>14 (7)</strong></td>
<td><strong>17 (7)</strong></td>
<td><strong>62 (28)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Extraction data

<table>
<thead>
<tr>
<th>Risk level</th>
<th>No. Patients</th>
<th>No. Patient with additional chemotherapy</th>
<th>Total No. of dental extractions</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk</td>
<td>30</td>
<td>12</td>
<td>197 (63)</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>18</td>
<td>5</td>
<td>101</td>
</tr>
<tr>
<td>Low risk</td>
<td>34</td>
<td>14</td>
<td>92</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>82</strong></td>
<td><strong>31</strong></td>
<td><strong>390</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subject</th>
<th>N =</th>
<th>ORN rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All dental extractions</td>
<td>390</td>
<td>0.26%</td>
</tr>
<tr>
<td>All patients</td>
<td>82</td>
<td>1.2%</td>
</tr>
<tr>
<td>Per ‘high risk’ dental extraction</td>
<td>63</td>
<td>1.6%</td>
</tr>
<tr>
<td>Per ‘high risk’ patient</td>
<td>30</td>
<td>3.3%</td>
</tr>
<tr>
<td>Mandibular dental extractions</td>
<td>232</td>
<td>0.0%</td>
</tr>
<tr>
<td>Maxillary dental extractions</td>
<td>158</td>
<td>0.6%</td>
</tr>
<tr>
<td>Non-primary closure</td>
<td>27</td>
<td>3.7%</td>
</tr>
<tr>
<td>Previous history of ORN</td>
<td>9</td>
<td>11.1%</td>
</tr>
<tr>
<td>Prophylaxis</td>
<td>Incidence</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>HBOT</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>P&amp;Ve</td>
<td>0.26-1.2%</td>
<td></td>
</tr>
</tbody>
</table>
# Implants

<table>
<thead>
<tr>
<th>Author</th>
<th>No. of Implants</th>
<th>Implant Success</th>
<th>ORN Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patel</td>
<td>194</td>
<td>94.8%</td>
<td>0%</td>
</tr>
<tr>
<td>Hammond(^1)</td>
<td>341</td>
<td>94.4%</td>
<td>Not stated</td>
</tr>
<tr>
<td>Ch’ng(^2)</td>
<td>695</td>
<td>96.8%</td>
<td>7.7%</td>
</tr>
</tbody>
</table>


Research

- Quality of Life
- Vascular Endoscopy
- Pve Prophylactic
  - RfPB
- PhD
Future

• Audit
• Research
• Review of protocol 2017
• Work in conjunction with other units
  • Regional
  • National
Thank you – Questions?

Vinod Patel vinod.patel@gstt.nhs.uk

Chris Sproat chris.sproat@gstt.nhs.uk

Jaw Necrosis Clinic
Floor 23, Oral Surgery Dept
Tower Wing
Guys Dental Hospital
London Bridge
London
SE1 9RT
Summary and close

Mr Peter Clarke, Chair of the LCA Head and Neck Pathway Group
Closing remarks

Thank you all for coming today

Please look out for the enhanced recovery self assessment and return your questionnaire promptly.

Please contact Elizabeth Pegers, LCA Project Manager if you would like a copy of the slides including any data and metrics, or have any queries or comments regarding today’s event or the work of the Pathway Group at:

epeegers@nhs.net